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PELVIC CELLULITIS.

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THE interspaces between the organs and tissues within the pelvis are filled with cellular tissue. But the cellular tissue surrounding the supra-vaginal portion of the neck of the uterus, and that lying between the folds of the broad ligaments, is the seat of the cellular inflammation within the pelvis so common in women who have borne children. It is rare to examine a multipara without finding evidences of pelvic cellulitis or parametritis. Injuries incident to parturition largely account for this, and among them laceration of the cervical canal is, perhaps, the most common, occurring, as it does, in about 30 per cent. of all cases. Septic matter is carried from the injured and abraded surfaces, by means of the blood-vessels and the lymphatics, to the cellular structure, and the cellulitis that follows becomes septic in character. The Fallopian tubes are not affected, unless pelvic cellulitis is secondary to pelvic peritonitis resulting

from an extension of inflammation from the tubes to the peritoneum. Primary pelvic cellulitis and inflammation of the tubes are, however, associated, in cases of a high grade of inflammation, or when both are of long standing. The frequent association of the two has led some to believe that pelvic cellulitis is an outgrowth of tubal disease, instead of resulting primarily from septic contamination from parturient injuries. When the association is present, pelvic peritonitis is the intervening link.

Pelvic cellulitis is easily recognized by means of a vaginal examination. Tenderness and hardness of the lateral uterine fornices, partial obliteration of the uterine cervix, and more or less a limitation to the natural mobility of the uterus indicate both the presence and degree of cellulitis. If the inflammatory exudation has been great, a tumor of a varying size may be found on either side of the uterine cervix, pushing the uterus in the opposite direction. If the tumor is large and extends above the superior strait of the pelvis, it may be felt through the abdominal wall. The tumor may disappear by resolution or pass into a state of suppuration, and the pus may escape through the vagina, bladder, rectum, or abdominal walls.

Pelvic cellulitis, especially when following parturition, should be early recognized. The efforts of treatment should be directed to the controlling of pain and to limiting the tendency to an exudation. Opium, for the relief of pain; counter-irritants or hot applications over the uterus, and the use of the hot, antiseptic, vaginal douche for limiting the exudation; and quinine and supporting measures, if suppuration follows. Should an exudation take place, the tumor may pass away by resolution, and, if pus forms, it may find its way out through the vagina, bladder, rectum, or the abdominal walls. In the event of pus being retained, aspiration should be performed, and the operation repeated, if the sac refills. If the pus-secreting character of the sac remains after aspiration has been once repeated, the introduction of a drainage-tube into the sac and flushing the sac-cavity with an antiseptic solution may be required. When the abscess cannot be reached *per vaginam*, and septicæmia threatens, laparotomy and drainage through the abdominal walls are called for.

Reprinted from "The Medical Bulletin,"
November, 1891.